CHAPTER 7: THREE-YEAR GOALS AND OBJECTIVES

This three–year HIV Prevention Comprehensive Plan outlines a strategy to respond appropriately to the epidemic and reduce risk behaviors among those at greatest risk for HIV infection. One-year objectives consistent with this plan are established annually by the DHEC STD/HIV Division's application for federal funding from the Centers for Disease Control and Prevention. The Plan's overall goal is to maximize the use of federal, state, and other resources to strengthen prevention efforts.

The *HIV Prevention Strategic Plan Through 2005* developed by the Centers for Disease Control and Prevention states that "to succeed, HIV prevention efforts must be comprehensive and science-based". The *Plan* outlines the following elements of successful HIV Prevention Programs:

- An effective community planning process
- Epidemiologic and behavioral surveillance; compilation of other health and demographic data relevant to HIV risks, incidence or prevalence
- HIV counseling, testing and referral and partner counseling and referral, with strong linkages to medical care, treatment and needed prevention services
- Health education and risk reduction activities, including individual-, group- and community-level interventions
- Accessible diagnosis and treatment of other STDs
- Public information and education programs
- Comprehensive school health programs
- Training and quality assurance
- HIV prevention capacity-building activities
- An HIV prevention technical assistance assessment and plan
- Evaluation of major program activities, interventions and services

The Goals, Objectives and Strategies of this HIV Prevention Plan address each of these essential components. Additionally, the objectives address areas identified in the Needs Assessment as unmet needs or areas to address through enhanced/improved prevention planning efforts.

1. Community Planning

Goal 1: To foster the openness and participatory nature of the community planning process to ensure parity, inclusiveness and representation.

Objectives:

1. By 2002, increase linkages between local HIV prevention collaborations and the statewide community planning group to improve communication and participation of local collaboration planning initiatives in the statewide planning process.

2. By 2002, increase opportunities for other community leaders, representatives, and members of the target populations to participate in the planning process.
3. By 2004, continue orientation, training and mentorship activities for new members each year.

Goal 2: To ensure that the community planning group reflects the diversity of the epidemic in South Carolina and that expertise in epidemiology, behavioral science, health planning and evaluation are included in the process.

Objectives:

1. By January 2002, refill epidemiology and behavioral science membership of the CPG for 2002 through recruitment and selection by the membership committee.
2. By July 2002, review current membership composition and determine positions needed for recruitment for 2002/2003 to have complete 30-member planning group.

Goal 3: To ensure the priority HIV prevention needs are determined based on an epidemiologic profile of the South Carolina HIV epidemic and a comprehensive needs assessment.

Objectives:

1. By 2002, complete updated Epi Profile utilizing HIV/AIDS and STD surveillance, existing behavioral and other data through 2001.
2. By 2002, consider priority populations and interventions based on revised epiprofile, and short term needs assessment and make adjustments as appropriate based on data/information.
3. By 2003, complete Phase II of comprehensive needs assessment focusing on priority populations' risk behaviors and HIV prevention needs.
4. By 2003, complete phase III of comprehensive needs assessment with priority population round tables to provide further insight on risk behaviors and prevention needs identified through Phase II assessments.
5. By 2004, update resource inventory and conduct gap analysis.
6. By 2004, utilizing epi profile and needs assessment data, conduct priority setting of populations.

Goal 4: Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, theory (from social and behavioral science), and community norms and values.

Objectives:

1. By 2002, update review of literature for effective HIV prevention interventions.
2. By 2002, based on updated literature on interventions and 2001 short-term needs assessments information, review 2001 priority interventions, make revisions as appropriate and prioritize interventions for each population.

3. By 2003 - 2004, update profile on effective interventions and complete priority setting process for interventions based on comprehensive needs assessments and literature review.

Goal 5: To foster strong, logical linkages (or connections) between the community planning process, plans, application for funding, and allocation of CDC HIV prevention resources.

Objective:
1. By 2002 – 2004, maintain process to document linkages between the prevention plan, application and allocation of HIV prevention funds.

2. Epidemiologic and Behavioral Surveillance

Goal: To develop an integrated surveillance system to measure incidence of new infections, to track the prevalence of disease, to monitor behaviors that place people at risk for HIV infection in order to provide more comprehensive, meaningful data for planning and evaluation.

Objectives:

1. By 2002, develop and implement feasible behavioral and seroprevalence surveillance activities with priority populations using sentinel surveillance models.

2. By 2004, utilize enhanced surveillance data in the priority setting process.

3. HIV Counseling, Testing, and Partner Referral Services

Goals:

- Provide individuals a convenient opportunity to learn their current HIV serostatus, and participate in counseling to help initiate and maintain behavior change to avoid infection, or if already infected, to prevent transmission to others.
- Implement and maintain a system to ensure clients who are HIV positive receive appropriate counseling and are entered and maintained in an appropriate system of care, including prevention services.
- Provide confidential, voluntary, client-centered counseling and referral of sex and needle-sharing partners of HIV-infected persons.

Objectives:

1. By 2002, increase access to community delivered prevention services in 95% of counties with HIV prevalence rates among African Americans >500.0.

2. By 2004, reduce HIV related morbidity/mortality by increasing proportion of under-served/uninsured HIV infected people in South Carolina who are linked to appropriate care and treatment services from estimated 50% to 80%.

3. By 2002, assure that 100% of the individual with newly identified HIV infection in publicly funded sites receive, either directly or through referral, access to appropriate primary and secondary prevention services including CD4 testing, TB testing, and early intervention services.

4. By 2002, partner notification services will be provided to at least 60% of all newly reported persons with HIV disease, and 95% of those screened for "eligibility" for follow-up by local health department staff.

4. Health Education/Risk Reduction (HE/RR):

Goals:

- Provide individual, group and community level HE/RR activities in accordance with prioritized target populations and interventions identified in the Comprehensive HIV Prevention Plan.
- Provide resources to minority and other community-based organizations to implement HE/RR activities.

Objectives:

Target Population 1: African American Men Who Have Sex With Men (MSM) Ages 15-44.

1. By 2004, increase by 25% the proportion of African American Men Who Have Sex With Men (MSM) Ages 15-44 who report risk reduction practices through outcome monitoring and sentinel surveillance data.

2. By 2002, increase by 50% the proportion of African American Men Who Have Sex With Men (MSM) Ages 15-44 who participate in peer or non-peer led small group, multi-session skills building education for the adoption and maintenance of HIV risk reduction behaviors. At least two will occur in correctional settings. Baseline = 1053.

Target Population 2: African American Women Who Have Sex With Men (WSM) Ages 15-44.

1. By 2004, increase by 25% the proportion of African American Women Who Have Sex With Men (WSM) Ages 15-44 who report risk reduction practices through outcome monitoring and sentinel surveillance data.

2. By 2002, increase by 50% the proportion of African American Women Who Have Sex With Men (WSM) Ages 15-44 who participate in individual level multi-session skills building education for the adoption and maintenance of HIV risk reduction behaviors, provided to one person at a time.

3. By 2002, increase by 50% the proportion African American Women Who Have Sex With Men (WSM) Ages 15-44 who participate in peer-led and non-peer led group-level multi-session education interventions in housing centers and other community settings. Baseline = 2500.

Target Population 3: White Men Who Have Sex With Men (MSM) Ages 15-44.

1. By 2004, increase by 25% the proportion of White Men Who Have Sex With Men (MSM) Ages 15-44 who report risk reduction practices through outcome monitoring and sentinel surveillance data.

2. By 2002, increase by 50% the proportion of White Men Who Have Sex With Men (MSM) Ages 15-44 who participate in group level, multi-session education interventions program to reduce HIV risks. Baseline = 880

Target Population 4: African American Male Injecting Drug Users (IDU) Ages 20-44.

1. By 2004, increase by 25% the proportion of African American Male Injecting Drug Users (IDU) Ages 20-44 who report risk reduction practices through outcome monitoring and sentinel surveillance data.

2. By 2002, increase by 50% the proportion of African American Male Injecting Drug Users (IDU) Ages 20-44 who participate in peer or non-peer delivered outreach education and distribution of intervention "kits" to reduce HIV risks. Baseline = 52.

3. By 2002, increase by 50% the proportion African American Male Injecting Drug Users (IDU) Ages 20-44 who are involved in group education sessions conducted in drug abuse treatment centers, prison, or shelters. No baseline data available at the moment.

4. By 2002, increase by 50% the proportion of African American Male Injecting Drug Users (IDU) Ages 20-44 who participate in community wide events increasing knowledge of HIV risks, HIV prevention and risk reduction. No baseline data available at the moment.

Target Population 5: White Males Injecting Drug User Ages 20-44.

1. By 2004, increase by 25% the proportion of White Male Injecting Drug Users (IDU) Ages 20-44 who report risk reduction practices through outcome monitoring and sentinel surveillance data.

2. By 2002, increase by 50% the proportion of White Male Injecting Drug Users (IDU) Ages 20-44 who participate in peer or non-peer delivered outreach education and distribution of intervention "kits" to reduce HIV risks. Baseline = 40

3. By 2002, increase by 50% the proportion of White Male Injecting Drug Users (IDU) Ages 20-44 who are involved in skills-based group education sessions conducted in drug abuse treatment centers, prison, or shelters. No baseline data available.

Target Population 6: African American Female Injecting Drug User Ages 20-44.

1. By 2004, increase by 25% the proportion of African American Female Injecting Drug Users (IDU) Ages 20-44 who report risk reduction practices through outcome monitoring and sentinel surveillance data.

2. By 2002, increase by 50% the proportion of African American Female Injecting Drug Users (IDU) Ages 20-44 who participate in peer or non-peer delivered outreach education and distribution of intervention "kits" to reduce HIV risks. Baseline = 77

3. By 2002, increase by 50% the proportion of African American Female Injecting Drug Users (IDU) Ages 20-44 who are involved in skills-based group education sessions conducted in drug abuse treatment centers, prison, or shelters.

5. Access to STD Diagnosis and Treatment:

Goal:

- Provide continued coordination and integration of HIV prevention and STD screening and treatment programs to reduce transmission of HIV and other STDs.

Objectives:

1. By 2002, continue to provide increased access to STD and HIV and family planning services through mobile screening services in counties of highest syphilis and HIV rates.

2. By 2002, continue to provide integrated STD, HIV, Immunizations and family planning services through county health department clinics.

3. By 2002, continue to provide integrated jail screening partnering with syphilis elimination efforts.

6. Public Information:

Goal:

- Provide a variety of public information activities to general audiences to dispel myths and address barriers to effective prevention programs, and to persons at increased risk for HIV and STDs to support efforts for personal risk reduction and assist in locating available prevention and care resources.

Objectives:

1. By 2002, purchase or develop culturally appropriate materials and public information items for priority populations.

2. By 2002, provide targeted radio and other media awareness opportunities to increase HIV and STD awareness and promote knowledge of HIV serostatus.

5. Quality Assurance and Training:

Goal:

- Develop and implement quality assurance procedures and training for staff providing prevention services including contracted organizations.

Objectives:

1. By 2002, provide on-going technical assistance and contract modifications/monitoring of 11 collaborations to increase number of interventions available to priority populations as reflected in the statewide prevention plan.

2. By 2002, provide on-going quality assurance monitoring of prevention counseling staff.

6. HIV Prevention Capacity-Building:

Goal:

- Provide financial and technical assistance to strengthen both the public health infrastructure and that of non-governmental organizations to deliver effective HIV prevention interventions.

Objectives:

1. By 2002, conduct at least eight training events on behavioral interventions to address training needs of local prevention staff/organizations.

2. By 2002, conduct at least 4 basic HIV prevention counseling training courses and 4 HIV Basic Facts courses for local prevention staff.

3. By 2004, conduct anual "Leadership Summit" conferences for community planning group members and local prevention collaborations to increase knowledge and skills in prevention planning and evaluation.

4. By 2002, continue to provide resources to minority and other community-based organizations to implement HE/RR activities through collaboration with the Office of Minority Health, NMAC technical assistance, and other partners.

7. Evaluation of Major Program Activities, Interventions and Services:

Goal:
Develop and conduct evaluation activities that provide meaningful information on the effectiveness and impact of HIV prevention programs and the community planning process.

Objectives:

1. By 2002, continue to evaluate the HIV prevention community planning process according to the activities in this Plan.

2. By 2002, evaluate local intervention plans to ensure consistency with the priority populations and interventions in this Plan.

3. By 2002, conduct process and outcome evaluation activities of HIV prevention programs to determine if target populations are being reached, if selected programs are effective in changing behaviors, and to provide meaningful information to enhance community planning.

4. By 2002, evaluate linkages with the comprehensive HIV prevention plan and the application for funding.

5. By 2004, utilize sentinel surveillance data with selected priority populations to assess effectiveness of prevention efforts and enhance community planning priority setting process.